TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Fondren Orthopedics

Respondent Name
United Airlines Inc

MFDR Tracking Number
M4-17-2656-01

Carrier's Austin Representative
Box Number 48

MFDR Date Received
May 9, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please reprocess this claim to the carrier see page 2 of the claim form correct g codes were added to support 97001/GP."

Amount in Dispute: $121.35

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: ""The provider is billing 97001, a G code should also be billed as per above rule. Original bill, DCN 2016277GJ003011 finalized 10/06/16. Appears the provider then billed G codes. DCN 2017009DD043692 denied This item was previously submitted and reviewed with a notification of decision issued to payor, provider (duplicate invoice) (carrier receipt date 01/09/17) DCN 2017048DD008026 denied Date (s) of service exceed (95) day time period for submission per RULE 408.027 and Bulletin No. B-0037-05A. (BF06) (carrier receipt date 02/17/17)."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 27, 2016	97001	$121.35	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
4. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.

5. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
6. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical claim.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing
   - W3 – Request for reconsideration
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - 18 – Duplicate of claim/service
   - 29 – The time limit for filing has expired

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for Code 97001 – "Physical therapy evaluation" for date of service September 27, 2016. The insurance carrier denied disputed services with claim adjustment reason code 4 – "The procedure code is inconsistent with the modifier used or a required modifier is missing." 28 Texas Administrative Code §134.203 (b) requires that,

   > For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
   >
   > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

   Review of the applicable Medicare payment policy found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf Medicare Claims Processing Manual, Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services which states,

   > *G. Required Reporting of Functional G-codes and Severity Modifiers*
   > *The functional G-codes and severity modifiers listed above are used in the required reporting on therapy claims at certain specified points during therapy episodes of care. Claims containing these functional G-codes must also contain another billable and separately payable (non-bundled) service. Only one functional limitation shall be reported at a given time for each related therapy plan of care (POC). Functional reporting using the G-codes and corresponding severity modifiers is required reporting on specified therapy claims. Specifically, they are required on claims:*
   >
   > *• At the outset of a therapy episode of care (i.e., on the claim for the date of service (DOS) of the initial therapy service);*
   > *• At least once every 10 treatment days, which corresponds with the progress reporting period;*
   > *• When an evaluative procedure, including a re-evaluative one, (HCPCS/CPT codes 92521, 92522, 92523, 92524, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97161, 97162 ,97163, 97164, 97165, 97166, 97167, 97168) is furnished and billed;*
   > *• At the time of discharge from the therapy episode of care–(i.e., on the date services related to the discharge [progress] report are furnished); and*
   > *• At the time reporting of a particular functional limitation is ended in cases where the need for further therapy is necessary.*
   > *• At the time reporting is begun for a new or different functional limitation within the same episode of care (i.e., after the reporting of the prior functional limitation is ended)*
   >
   > *Each reported functional G-code must also contain the following line of service information:*
   > *• Functional severity modifier*
   > *• Therapy modifier indicating the related discipline/POC -- GP, GO or GN -- for PT, OT, and SLP services, respectively*
   > *• Date of the related therapy service*

• Nominal charge, e.g., a penny, for institutional claims submitted to the A/B MACs (A). For professional claims, a zero charge is acceptable for the service line. If provider billing software requires an amount for professional claims, a nominal charge, e.g., a penny, may be included.

Review of the submitted documentation found a claim with the required functional G-codes however, the carrier denied this claim with claim adjustment reason code: 29 – "The time limit for filing has expired."

28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." Texas Labor Code §408.0272(b) provides that:

> Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:
>
> (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:
>
> (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;
>
> (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or
>
> (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title; or
>
> (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the health care provider was required to submit the medical bill not later than 95 days after the date the disputed services were provided.

Texas Labor Code §408.027(a) states that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that:

> Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:
>
> (1) the date received, if sent by fax, personal delivery or electronic transmission or,
>
> (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.

Review of the submitted information finds no documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Consequently, the requestor has forfeited the right to reimbursement due to untimely submission of the medical bill, pursuant to Texas Labor Code §408.027(a).

2. The Division finds the carrier's denial is supported as required billing and coding requirements of Rule 134.203 (b) was not met on the initial submission of the claim.

   The correction of the claim constitutes a new bill which was required to be filed within 95 days of the date of service. No additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		June 8, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.